GEORGIA DEPARTMENT OF CORRECTIONS **Standard Operating Procedures**		
Policy Name: Offender Death and Mortality Reviews		
Policy Number: 507.04.67	**Effective Date:** 01/27/2022	**Page Number:** 1 of 8
Authority: Commissioner	**Originating Division:** Health Services Division	**Access Listing:** Level I: All Access

I. Introduction and Summary:

Accurate information and timely reporting will occur upon the death of any offender in the custody of Georgia Department of Corrections (GDC). Deaths that are unexpected or occur under unusual circumstances will be investigated in accordance with State and Local regulations. Performance of a thorough Peer Reviewed Mortality Review is required for all deaths in custody. Mortality review is a form of peer review and follows the rules and enjoys the protections described under Peer Review in Standard Operating Procedure (SOP) 507.01.12. This policy is applicable to all facilities that house GDC offenders including county and Private Prisons.

II. Authority:

A. O.C.G.A. §§ 45-16-20, *et seq.*, and 31-7-130 *et seq.*;

B. Ga. Comp. R. & Regs. R. 125-4-4-.10, 125-4-4-.11, and 125-2-4-.20;

C. GDC SOPs: 208.03 Death of An Offender and 507.01.12 Continuous Quality Improvement;

D. NCCHC 2018 Adult Standards: P-A-09 and P-A-06; and

E. ACA Standard: 5-ACI-6C-16, 4-ALDF-4D-23, 4-ALDF-4D-24, 4-ALDF-4D-25, and ACRS-5A-18-1.

III. Definitions:

A. **Administrative Mortality Review** - An assessment of correctional and emergency response actions surrounding an offender's death. Its purpose is to identify areas where facility operations and/or policies and procedures can be improved.

B. **Clinical Mortality Peer Review** - An assessment of the clinical care provided at a facility and the circumstances leading up to a death. Its purpose is to identify areas of patient care and/or system policies and procedures that can be improved.

C. **Peer Reviewed Mortality Review** - A form of peer review conducted for the purpose of evaluating and improving the quality and efficiency of health care

rendered with the aim to educate providers and to reduce morbidity and mortality. Administrative Mortality Review and Clinical Mortality Peer Review are types of Peer Reviewed Mortality Review.

D. **Psychological Autopsy** - Sometimes referred to as a psychological reconstruction or postmortem, a written reconstruction of an individual's mental health status with an emphasis on factors that led up to and may have contributed to the individual's death. It is usually conducted by a psychologist or other qualified mental health professional.

IV. Statement of Policy and Applicable Procedures:

A. General Information:

1. Each institution will designate a person, usually medical records staff, to be responsible for the handling of all medical records pertaining to deceased offenders. The original chart should remain at the institution until the Peer Reviewed Mortality Review process is completed and then be forwarded to the GDC Office of Health Services at Central Office.

B. Natural Death:

1. Following the death of an offender, the Medical Director or designee will immediately notify:

   a. Warden/Superintendent;

   b. The facility duty officer;

   c. The Health Services Administrator; and

   d. Other personnel as needed.

2. The Warden/Superintendent or designee will notify the County Coroner and, through the State Communication Center, notify the GDC Commissioner, Regional Director, and the GDC Health Services Director.

3. An Offender Death Notification Form, P47-0005.01, will be submitted (faxed) to the GDC Statewide Medical Director the next working day. It must be completed by a clinical qualified health professional. If death occurs at a facility without a full-time Medical Director, the nurse will notify the Medical Director covering the facility to have the Offender Death Notification Form completed and submitted. This form will include the date on which the Clinical Mortality Peer Review has been scheduled. Scheduling should allow sufficient time for the Medical Director of GDC or designee to make plans to attend the Clinical Mortality Peer Review, if desired.

4. The Warden/Superintendent or designee will be responsible for contacting the offender's family or next of kin. The Responsible Health Authority will be available to discuss the incident surrounding the offender's death.

5. All staff of the GDC will treat each offender death with respect and compassion and seek to involve the offender's family/next of kin whenever feasible, especially in cases where imminent death is expected.

6. After proper medical examination by a physician and consent of the County Coroner, the body will be released to a funeral home. The funeral home representative will document receipt of the body.

C. Unusual Death:

1. If a death occurs as a result of suicide, homicide, accidental or suspicious circumstances, the GDC Commissioner and GDC Statewide Medical Director will be notified immediately.

2. The Warden/Superintendent or designee will be responsible for notifying the Georgia Bureau of Investigations (GBI). In such cases, the body will not be removed without the permission of the GBI and the County Coroner. All steps will be taken to preserve the scene.

3. In cases where the cause of death is unclear or where an undiagnosed communicable disease is suspected, all reasonable attempts will be made to obtain a complete autopsy via the GBI.

D. Clinical Mortality Peer Review:

1. Clinical Mortality Peer Review is required to be conducted for all deaths in custody and will be performed by a committee chaired by:

   a. Health Service Administrator (HSA);

   b. The institutional Medical Director;

   c. Responsible Physician; and

   d. Regional Medical Director or designee.

2. Other committee members may be:

   a. Director of Nursing (DON);

   b. Dentist;

   c. Pharmacist; or

   d. Other licensed institutional staff involved in CQI activities.

3. As in any other peer review activity, the committee should be composed of peers, that is, licensed providers of equal or higher rank than the provider(s) rendering services to the case being discussed.

4. In certain cases, the committee members may wish to call other health care providers, such as health records staff, nurses, etc., in order to better understand the circumstances of the case.

5. Following their interview, these non-peers may be excused, and the clinical mortality review process may continue.

6. If a given institution does not have a sufficient number of peers to proceed, licensed providers from other institutions may need to be invited to participate.

7. The contract vendor of health services may appoint other physicians for the review including contract vendor physicians.

8. The Statewide Medical Director of the GDC or designee may attend at any time.

9. The Mortality Review Case Abstract form (P47-0005-06) will be completed by the Clinical Mortality Peer Review Committee.

10. At all times during the Clinical Mortality Peer Review process, attention should be paid to any indications that the decedent may have had undiagnosed and/or untreated communicable diseases. These are matters of public health and may need rapid action, such as contact tracing and appropriate communications to Public Health Authorities and the Office of Health Services.

11. The Clinical Mortality Peer Review will be completed within 21 working days from the death of the offender and form P47-0005-06, along with the other mortality review forms referenced in paragraph IV.E.2, below, will be mailed to the GDC Office of Health Services (OHS) within 31 working days of the offender's death.

12. If an immediate action is required based on the results of the Clinical Mortality Peer Review, those issues will be discussed with the appropriate providers.

E. Administrative Mortality Review:

1. The Administrative Mortality Review is required to be conducted by the Office of Health Services for all offender deaths in custody and is the process of

establishing all facts surrounding the offender's death in order to:

a. Ascertain institutional compliance with the standard of care;

b. Educate health care staff about trends and causes of offender deaths; and

c. Correct any identified deficiencies that may have contributed to the offender's death.

2. The Administrative Mortality Review form, P47-0005.04, will be completed within fifteen (15) working days of an offender's death by the Health Services Administrator. It will be mailed, along with the offender's physical and mental health records and the other Mortality Peer Review Forms (Offender Death Notification Form P47-0005.01; Clinical Mortality Peer Review Premorbid Care P47-0005-02; Terminal Event Care, P47-0005-03; Community Standards Rating P47-0005-05; and Case Abstract P47-0005-06) to the GDC Office of Health Services within twenty (20) days of the offender's death. OHS will perform an executive peer review of each offender death based on these records.

3. Any corrective actions identified in the Administrative Mortality Review will be implemented and monitored through the facility's CQI program for systemic issues.

F. The Mortality Review Committee:

1. The Peer Reviewed Mortality Review will be conducted by a committee composed of a representative number of the following:

a. Nurse Practitioners;

b. Physician Assistants;

c. Nurses;

d. Mental Health Provider; and

e. A Security Representative.

2. The Mortality Review Committee will meet as needed.

3. The Committee will review all Clinical Mortality Peer Review packets submitted for review by the GDC Statewide Medical Director.

4. The Committee will identify peer related physical health issues and develop corrective action as needed.

5. The Committee will identify any need for a Forensic Autopsy.

6. The Committee will identify any administrative opportunities for improvement.

7. The Committee will notify the GDC and contract vendor Statewide Medical Directors of any positive findings.

8. A Psychological Autopsy will be conducted by the GDC Mental Health designee as may be required.

9. The original Clinical Mortality Peer Review form, P47-0005.05, will be stamped "Peer Review" and sent to the Office of Health Services.

10. For audit purposes, a Mortality Log is the only record to be maintained at the facility and will include:

    a. The offender’s GDC number;

    b. Offender name;

    c. Date of death; and

d. Dated signatures of the clinical and administrative reviewers (and psychologist if a suicide) to signify the clinical and administrative review.

11. In accordance with the legal protections which are accorded peer review processes, copies of the mortality review forms referenced in this policy are not to be maintained/retained at the facility.

    Note: All forms associated with this SOP may be found on the GDC Intranet at Captiva/Resources/Health Services Documents/02 Physical Health/Health Record Manual.

V. Attachments: None.

VI. Record Retention of Forms Relevant to this Policy:

Upon completion, all forms shall be maintained together as the Mortality Peer Review Packet at OHS for ten (10) years.